Your Guide
to
Workers Compensation

Division of Human Resources
Workers Compensation Section
325 Whitmore Administration Building
545-6114

Employee's Checklist for Worker's Compensation

Employee reports any work-related injury or illness to his/her supervisor. The supervisor arranges for any **immediate medical attention** required, after which:

- ☐ 1. **Before seeking medical treatment (or within 24 hours following emergency medical treatment**) the employee or his/her medical provider must call the state insurer's Utilization Review agent for approval of treatment: **1-800-266-7991**

- ☐ 2. **Within 48 hours of the injury**: the supervisor and employee complete, sign and forward the *Notice of Injury Report* to Human Resources. The employee's completed *Authorization for Release of Medical Information* (attached to the NOI) form is submitted at the same time.

- ☐ 3. **If the employee is out more than 5 days,** the supervisor :
  - ☐ Submits a completed *Form 101* to Human Resources,
  - ☐ Contacts the employee to verify if he or she wants to use accrued time until WC is approved and submits Time & Attendance accordingly.

- ☐ 4. **After receipt of the Form 101** by HR, the WC agent sends the employee a packet of information that includes 2 forms to be completed and returned to HR:
  - ☐ *Physician's Report*,
  - ☐ *Concurrent Employment Review Form.*

- ☐ 5. HR sends a memo and PA to the Department confirming that the Form 101 has been received and employee's PeopleSoft status is PLA/WKC.

  The Department continues reporting Time & Attendance in keeping with the employee's instructions until WC has been approved or denied.

- ☐ 6. HR sends a memo to the Department confirming approval / denial of the WC claim. Department begins submitting Time & Attendance using IAI code until further notice. (IOD code is used for IBPO members.)

- ☐ 7. **Employee notifies his or her supervisor of the return to work date. The department notifies HR as soon as possible**, lest the employee be overpaid by the WC agent.

- ☐ 8. Human Resources copies the department on a PA returning the employee to active duty in PeopleSoft.

Table of Contents

What is Workers Compensation?

Workers compensation is a type of insurance that's provided by state law to employees who are injured on the job or who contract a work-related illness. Workers compensation is a "No-Fault System," which means employees do not have to prove blame in order to collect wage and medical benefits. However, the burden is on the employee to prove that a disability is work-related. Chapter 152 of the Massachusetts General Laws establishes guidelines and provisions for the continuation of compensation coverage and payment of medical bills when employees are injured on the job and unable to work.

Scope of Coverage

Anyone who is currently being paid on the University payroll is covered by Workers Compensation insurance regardless of whether the work location is on or off campus. Coverage applies to: classified and hourly staff, professional non-academic staff, faculty, graduate employees, and student personnel.

How Workers Compensation is Administered

University of Massachusetts Amherst - The Benefits section of Human Resources assists campus departments and injured employees with workers compensation issues, incidents and claims processing. We also serve as a liaison between the state Workers' Compensation Unit, the Department of Industrial Accidents (DIA), and University employees. Our office is located in Room 325, Whitmore Administration Building, and the phone number is 545-6114. ☎

State Insurer - The Commonwealth's Human Resources Division (HRD) is the University's Workers Compensation (WC) insurance provider. The state's WC Unit, is responsible for developing and administering policies and procedures for all state employees. It also reviews injury reports, decides which claims are compensable, and has a Utilization Review Board that reviews/authorizes medical care and treatment protocols.

[State] Department of Industrial Accidents (DIA) - The DIA represents the interests of employees who have been injured on the job. It settles disputes between the state insurer and employees. Employees may seek recourse through a four-step process: Conciliation, Conference with DIA Board, Hearing with an Administrative Judge, and Hearing before a Reviewing Board.

Reporting a Work-Related Injury or Illness

If you are injured on the job or suffer a work-related illness, your supervisor or department personnel officer should be notified *immediately*. *Every* injury or work-related illness must be reported, regardless of whether it might seem relatively minor or insignificant. You should report the nature of the injury and the circumstances surrounding the incident.

Seeking Medical Treatment

If you need medical attention for a work-related injury or illness, you may seek treatment from your own health care provider *or* receive initial treatment from the University Health Services (UHS). UHS refers employees to the Cooley Dickinson Hospital in Northampton in cases where additional/immediate care is needed. The University's workers compensation insurance carrier will pay for any costs associated with your approved workers compensation claim.

You or your medical provider must call the state insurer's Utilization Review Agent for pre-approval of treatment or within 24 hours after seeking emergency treatment. The phone number is: 1-800-266-7991 ☎

Notice of Injury Report

Your supervisor or department personnel officer is responsible for filing a **Notice of Injury Report** 🗎 within 48 hours of the time when an incident occurs. The report establishes an official record of your injury/illness and is submitted to the Workers Compensation section of Human Resources, Room 325, Whitmore Administration Building.

☞ *A copy of the Notice of Injury Report form follows.*

Authorizing the Release of Medical Records

Your department will ask you to sign an **Authorization for Release of Medical Records** form. This form authorizes hospitals and medical providers to release any and all information relating to your injury, to persons and/or institutions involved in the Workers Compensation process. The state's Workers' Compensation Unit will not pay medical bills related to the injury unless it has received this authorization form.

If you are seriously injured and/or not immediately available to sign the form, your department will mail the Authorization to your home. Return the completed Authorization for Release of Medical Records form 🗎 to: *Human Resources, Attn: Workers Compensation Section, 325 Whitmore Administration Building, University of Massachusetts, Amherst, MA 01003.*

☞ *A copy of the Authorization for Release of Medical Records Report form follows.*

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE
HUMAN RESOURCES DIVISION
WORKERS' COMPENSATION SECTION
ONE ASHBURTON PLACE, BOSTON, MA 02108
(617) 727-3437

MITT ROMNEY
Governor

KERRY HEALEY
Lieutenant Governor

ERIC KRISS
Secretary

PATRICIA S. WADA
Personnel Administrator

NOTICE OF INJURY REPORT

MUST BE COMPLETED WITHIN 48 HOURS OF INCIDENT

DATE: _____ SOC.SEC.# _____

NAME _____
(Last) (First) (Middle)

ADDRESS _____

BIRTHDATE _____ AGE _____ SEX _____

AGENCY CODE	AGENCY NAME	AGENCY PAYROLL FUNDING SOURCE	
UMA1	UMASS Amherst 4	(A) STATE PAYROLL	_____
UMA2	UMASS Amherst 4	(B) TRUST FUNDED	_____
UMA3	UMASS Amherst 4	(C) FEDERAL FUNDED	_____

INJURY LOCATION _____

OCCUPATION _____ YEARS OF SERVICE _____

FULL TIME EMPLOYEE ____ PART TIME EMPLOYEE _____

NUMBBER OF HOURS WORKED PER WEEK _____

DATE OF INJURY _____ TIME OF INJURY _____ DATE OF NOTICE _____

BODY PART INJURED _____

NATURE OF INJURY _____

SIGNATURE OF W.C. AGENT OR DESIGNEE _____

SEVERITY OF INJURY: Please indicate your initial impression as to the severity of the claimed injury (please check as appropriate):

_____ (1) Minor injury; no likely lost time; no likely medical bills
_____ (2) Small injury; no likely lost time; possible medical bills
_____ (3) Moderate injury; possible lost time; probable medical bills
_____ (4) Significant injury; probably 0 to 5 days of lost time and medical bills
_____ (5) Severe injury; probably 5 plus days lost time and medical bills

NOTE: INJURED WORKERS ARE REQUIRED TO REPORT ANY EARNINGS RECEIVED FROM ANY SOURCE DURING THE PERIOD OF INCAPACITY.

TO BE COMPLETED
BY A SUPERVISOR

INTERNAL CLAIMS INVESTIGATION

Time of Injury:_____Place of Injury:_____

Describe how the injury occurred:_____

_____

_____

Was the claimant engaging in usual job activities: Yes:_____No:_____

Explain:_____

What parts of the body were injured?_____

Injury reported to:_____

Are you satisfied that the injury occurred as stated? Yes:_____No:_____

Explain:_____

Was the incident witnessed? Yes:_____No:_____

Provide the names of witnesses and ask that each prepare a witness statement in their <u>own handwriting</u> describing the event. Attach those statements to this report

Witness: Name_____Title_____Tel_____

Was the claimant hospitalized? Yes:_____No:_____

Is claimant a disabled veteran or has any other known disability?_____

PLEASE ATTACH A JOB DESCRIPTION OF CLAIMANT'S JOB IF AVAILABLE

Do you feel the injured worker would benefit from any referral to Rehabilitation? Yes:_____No:_____
Do you feel the claim warrants further investigation? Yes:_____No:_____
Please attach any information you feel would be useful to HRD-WC SECTION in managing this claim

Supervisor's
Signature_____Position_____

THE COMMONWEALTH OF MASSACHUSETTS
:XECUTIVE OFFICE FOR ADMINISTRATION AND FINANCE
HUMAN RESOURCES DIVISION
WORKERS' COMPENSATION SECTION
ONE ASHBURTON PLACE, BOSTON, MA 02108
(617) 727-3437

MITT ROMNEY
Governor

KERRY HEALEY
Lieutenant Governor

ERIC KRISS
Secretary

PATRICIA S. WADA
Personnel Administrator

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

CLAIMAINT'S NAME: _____

SOCIAL SECURITY #: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: _____

EMPLOYING AGENCY AND LOCATION: UMA UMASS Amherst 4

DATE OF INJURY: _____

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, *any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law.* I understand that HRD may share this information with my employer, medical and or vocational rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

SIGNATURE:_____DATE:_____

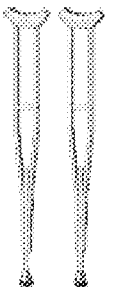
PLEASE COMPLETE THISAUTHORIZATION AND RETURN TO:

Human Resources Division
Workers' Compensation Section
One Ashburton Place, 3rd Fl.
Boston, MA 02108

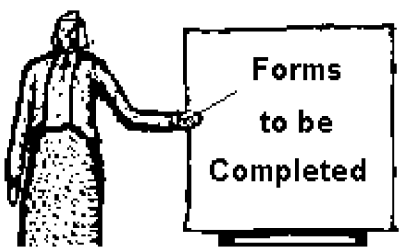
Where to Send Medical Bills

The state Workers' Compensation (WC) Unit is the insurer of your workers' compensation claim and is also the Utilization Review (UR) Agent for medical treatment related to your claim. If you seek medical attention or treatment for a work-related injury/illness, instruct your medical provider to send bills directly to:

Human Resources Division
Workers Compensation Unit
One Ashburton Place
Boston, MA 02108



Absence from Work for 5 Days or More



If you become disabled and are unable to work for a period of five or more calendar days, the following forms must be completed and submitted to: Workers Compensation section of Human Resources, Room 325, Whitmore Administration Building, University of Massachusettts, Amherst, MA 01003

Form 101 – First Report of Injury

If you are disabled and unable to earn full wages for a period of five or more calendar days, your department will fill out a **Form 101-First Report of Injury**. Form 101 must be submitted to the Workers Compensation section of Human Resources within seven (7) business days after the 5th calendar day of disability. Human Resources fills in University wage information, and forwards the form directly to the state Workers' Compensation (WC) Unit. Within 14 days of receiving Form 101, the state WC Unit must begin paying you for lost wages or send a denial letter explaining why the claim was not accepted.

☞ *A copy of the Form 101 follows.*

Physician's Report Form

Upon receiving the Notice of Injury - Form 101 from your department, the Workers Compensation section of Human Resources will send you a **Physician's Report**. Have your doctor fill out this form and return it to Human Resources *as soon as possible*. We will forward the completed form to the state Workers' Compensation Unit in Boston on your behalf.

☞ *A copy of the Physician's Report form follows.*

Since the state has a limited amount of time to reach a decision on your claim, it's important for your doctor to complete this form in a few days, or your claim may be denied due to lack of information.

Inform your doctor's office to send all bills concerning your workers' compensation claim directly to the state at the following address:

Human Resources Division
Workers' Compensation Unit
One Ashburton Place
Boston, MA 02108

FORM 101

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 101
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA USE ONLY

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

THIS FORM MUST BE FILED BY THE *EMPLOYER* IN THE EVENT OF AN INJURY THAT RESULTS IN DEATH OR FIVE OR MORE CALENDAR DAYS OF TOTAL OR PARTIAL INCAPACITY FROM EARNING WAGES.
INSTRUCTIONS AND CODES ON THE REVERSE SIDE **- Please Print Legibly or Type - Unreadable forms will be returned.**

EMPLOYEE

1. Employee's Name (Last, First, MI):	2. Home Telephone Number:	3. Social Security Number*:	4. Sex: ☐ M ☐ F
5. Home Address (No., Street, City, State & Zip Code):		6. Marital Status: ☐ M ☐ S	7. No. of Dependents:
8. Date of Hire (mm/dd/yyyy):	9. Date of Birth (mm/dd/yyyy):	10. Average Weekly Wage: $ ☐ Estimated ☐ Actual	

EMPLOYER

11. Employer's Name:	12. Federal Tax I.D. Number:
13. Employer's Address (No., Street, City, State & Zip Code):	14. Employer's Telephone Number:
	15. Industry Code (See Reverse Side):
16. Workers' Compensation Insurance Carrier and Tel. No. (NOT LOCAL AGENT/ADMINISTRATOR):	17. W.C. Policy Number:
18. Self-Insured? ☐ Yes ☐ No If Yes, Self-Insurer Number:	19. Business Type: ☐ Service ☐ Wholesale ☐ Mfg. ☐ Retail ☐ Other: _____

INJURY INFORMATION

20. DATE OF INJURY (mm/dd/yyyy):		
21. Was Employee Injured on Employer's Premises? ☐ Yes ☐ No	22. Location of Injury if not on Employer's Premises:	
23. FIRST day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	24. FIFTH day of Total or Partial Incapacity to Earn Wages (mm/dd/yyyy):	
25. If Employee has Died, Date of Death (mm/dd/yyyy):	26. Source of Injury (Chemicals, Machinery, etc.):	
27. Briefly Describe How Injury/Exposure Occurred and Body Part(s) involved:		
28. Person to Whom Injury was Reported (list position):	29. Date Reported (mm/dd/yyyy):	30. Date Reported as work related (mm/dd/yyyy):
31. Injury Code(s): Body Part Code(s) a. to body part a. b. to body part b. c. to body part c.	32. Witness(es) to Injury - Give Full Name(s), if none state as such:	
33. Has Employee Returned to Work? ☐ Yes ☐ No	34. Date Employee Returned to Work(mm/dd/yyyy):	
35. Employee's Regular Occupation:	36. Has Employee Returned to Regular Occupation: ☐ Yes ☐ No	
37. EMPLOYER'S Name (SEE INSTRUCTIONS ON REVERSE SIDE):	38. Title:	
39. EMPLOYER'S Signature (SEE INSTRUCTIONS ON REVERSE SIDE):	40. Date Prepared (mm/dd/yyyy):	

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of you report. Form 101 - Revised 8/2001 - Reproduce as needed

THIS FORM DOES NOT CONSTITUTE AN EMPLOYEE'S CLAIM FOR BENEFITS UNDER WORKERS' COMPENSATION.

EMPLOYER'S FIRST REPORT OF INJURY OR FATALITY

FILING INSTRUCTIONS

1. WHEN TO FILE: File this form within 7 calendar days, not including Sundays and legal holidays, of receipt of notice of any injury alleged to have arisen out of and in the course of employment, which totally or partially incapacitates an employee for a period of 5 or more calendar days from earning wages. This form is not an admission of liability, but must be filed even though the Employer may believe that the Employee is not injured, or that the Employee is not entitled to benefits under M.G.L. Chapter 152.

2. WHERE TO FILE: This form should be mailed to the Department of Industrial Accidents at the address shown on the front of the form. Copies must also be provided to the Employee and to the Employer's Workers' Compensation insurer.

3. PENALTIES: Failure to report injuries on this form may result in a fine of $100.00 in accordance with M.G.L. Chapter 152, Section 6.

4. EMPLOYER'S NAME & SIGNATURE IN BOXES 37 & 39: This form must be filed by the employer or an authorized agent/representative of the employer.

INDUSTRY CODES

Agriculture, Forestry and Fishing
01 Agriculture Production - Crops
02 Agriculture Production - Livestock
07 Agricultural Services
08 Forestry
09 Fishing, Hunting and Trapping

Mining
10 Metal Mining
12 Coal Mining
13 Oil and Natural Gas
14 Nonmetallic Minerals, Except Fuels

Construction
15 General Building Contractors
16 Heavy Construction, Ex. Building
17 Special Trade Contractors

Manufacturing
20 Food and Kindred Products
21 Tobacco Products
22 Textile Mill Products
23 Apparel and Other Textile Products
24 Lumber and Wood Products
25 Furniture and Fixtures
26 Paper and Allied Products
27 Printing and Publishing
28 Chemicals and Allied Products
29 Petroleum and Coal Products
30 Rubber and Misc. Plastic Products
31 Leather and Leather Products
32 Stone, Clay and Glass Products
33 Primary Metal Industries
34 Fabricated Metal Products
35 Industrial Machinery and Equipment
36 Electronic and Other Electrical Equipment
37 Transportation Equipment
38 Instruments and Related Products
39 Miscellaneous Manufacturing Industries

Transportation and Public Utilities
40 Railroad Transportation
41 Local and Interurban Passenger Transit
42 Trucking and Warehousing
43 U.S. Postal Service
44 Water Transportation
45 Transportation by Air
46 Pipelines, Except Natural Gas
47 Transportation Services
48 Communications
49 Electric, Gas and Sanitary Services

Wholesale Trade
50 Wholesale Trade - Durable Goods
51 Wholesale Trade - Nondurable Goods

Retail Trade
52 Building Materials and Garden Supplies
53 General Merchandising
54 Food Stores
55 Automotive Dealers and Service Stations
56 Apparel and Accessory Stores
57 Furniture and Home Furnishing Stores
58 Eating and Drinking Establishments
59 Miscellaneous Retail

Finance, Insurance and Real Estate
60 Depository Institutions
61 Non-depository Institutions
62 Security and Commodity Brokers
63 Insurance Carriers
64 Insurance Agents, Brokers and Service
65 Real Estate
67 Holding and Other Investment Offices

Services
70 Hotels and Other Lodging Places
72 Personal Services
73 Business Services
75 Auto Repair Services and Parking
76 Miscellaneous Repair Services
78 Motion Pictures
79 Amusements and Recreation Services
80 Health Services
81 Legal Services
82 Educational Services
83 Social Services
84 Museums, Botanical, Zoological Gardens
86 Membership Organizations
87 Engineering and Management Services
88 Private Households
89 Services, NEC

Public Administration
91 Executive, Legislative and General
92 Justice, Public Order, and Safety
93 Finance, Taxation, and Monetary Benefits
94 Administration of Human Services
95 Environmental Quality and Housing
96 Administration of Economic Programs
97 National Security and International Affairs

Non-classifiable Establishments
99 Non-classifiable Establishments

NATURE OF INJURY OR ILLNESS CODES

100 Amputation or Enucleation
110 Asphyxia or Strangulation Etc.
120 Burns (Heat)
130 Burns (Chemical)
140 Concussion
150 Contusion, Crushing, Bruise
170 Cut, Laceration, Puncture
180 Dislocation
200 Electric Shock, Electrocution
220 Fracture
250 Hernia, Rupture
300 Scratches, Abrasions
310 Sprains, Strains
400 Multiple Injuries
500 No Injury
950 Damage to Prosthetic Devices
965 No Other Injury, NEC**
999 Non-classifiable

Infection or Parasitic Diseases
150 Infective or Parasitic Disease, UNS*
151 Amebiasis
152 Anthrax
153 Brucellosis
154 Conjunctivitis and Ophthalmia
156 Tetanus
157 Tuberculosis
159 Other Infective or Parasitic Diseases

Dermatitis
180 Dermatitis, UNS*
183 Primary Infections of the Skin
184 Other Skin Conditions
185 Dermatitis, Allergenic or Contact
189 Skin Conditions, NEC**

Poisoning, Systemic
270 Poisoning, Systemic, UNS*
271 Due to Toxic Materials other than Lead
272 Diseases of the Blood and Blood Forming Organs
273 Upper Respiratory Conditions
274 Influenza, Pneumonia, Etc.
276 Other Diseases of the Gastro Intestinal Tract
278 Effects of Lead
279 Other Toxic Effects of One System Only

Respiratory Systems, Conditions of
370 Respiratory Systems, Conditions of
371 Upper Respiratory
372 Asthma, Influenza, Pneumonia

Pneumoconiosis
280 Pneumoconiosis
281 Silicotuberculosis
282 Anthracosis
283 Asbestosis
284 Byssinosis
285 Siderosis
286 Silicosis
287 Other Pneumoconioses
289 Pneumoconiosis and Tuberculosis

Nervous System, Conditions of
300 Nervous System, Conditions of - NEC**
301 Diseases of the Central Nervous System
302 Diseases of the Nerves and Peripheral Ganglia

Neoplasms Tumors
350 Neoplasm Tumor, UNS*
351 Malignant
352 Benign

Radiation Effects
290 Radiation Effects, UNS*
291 Non-Ionizing Radiation
292 Microwaves
293 Ionizing Radiation - X-Ray
294 Ionizing Radiation - Isotopes
295 Welder's Flash

Other
205 Carpal Tunnel Syndrome
510 Cardiovascular and Other Conditions of the Circulatory System
520 Complications Peculiar to Medical Care
530 Effects of Changes in Atmospheric Pressure
240 Effects of Environmental Heat
230 Effects of Exposure to Low Temperature
330 Eye, other Diseases of the Eye
250 Hearing Loss or Impairment
555 Heart Condition, Excludes Heart Attack
320 Hemorrhoids
360 Hepatitis, Serum and Infectious
272 Hepatitis, Toxic
260 Inflammation of Joints, Etc.
540 Mental Disorders
420 No Illness
999 Non-classifiable
590 Occupational Disease, NEC**
580 Symptoms and Ill-defined Conditions

BODY PART AFFECTED CODES

Head
100 Head, UNS*
110 Brain
120 Ear(s), UNS*
121 Ear(s), External
124 Ear(s), Internal
130 Eye(s), UNS*
140 Face, UNS*
141 Jaw, Chin
144 Mouth and Throat (vocal chords, larynx)
146 Nose
148 Face, Multiple Parts
149 Face, NEC**
150 Scalp
160 Skull
198 Head Multiple
200 Neck & Cervical Vertebrae

UPPER EXTREMITIES
300 Upper Extremities, NEC**
310 Arm(s), UNS*
311 Upper Arm
313 Elbow(s)
315 Forearm(s)
318 Arm(s), Multiple
319 Arm(s), NEC**
320 Wrist(s)
330 Hand(s), Not Wrist nor Fingers
340 Finger(s)
398 Upper Extremities, Multiple
400 Trunk, UNS*
410 Abdomen, Internal Organs, Inguinal Hernia
420 Back
430 Chest, Ribs, Breastbone, Internal Organs
440 Hip(s), Pelvis, Organs and Buttocks
450 Shoulder(s)
498 Trunk, Multiple

LOWER EXTREMITIES
500 Lower Extremities
510 Leg(s), UNS*
513 Knee(s)
515 Lower Leg(s)
518 Leg(s), Multiple
519 Leg(s), NEC**
520 Ankle(s)
530 Foot or Feet, Not Ankle
540 Toe(s)
598 Lower Extremities, Multiple
700 MULTIPLE PARTS
Applies when more than one major body part has been affected such as an arm and a leg.
999 NON-CLASSIFIABLE - Insufficient information to identify part of body affected. Includes damage to prosthetic devices.

*UNS - UNSPECIFIED

**NEC - NOT ELSEWHERE CLASSIFIED

Folk_OIG_PRR_112836

Physicians report here

Employment Outside the University

All injured workers must complete the **Concurrent Employment Review Form** 📄. The purpose of the Concurrent Employment Review is to ensure that individuals receive the appropriate compensation which is based on the loss of all earnings.

A. If you do not have another job outside of the University, write "None" on the line asking for the other employer's name and sign the bottom of the form. Return 📄 the Concurrent Employment Review form to:

Human Resources – Workers Compensation Section
181 President's Drive
Room 325, Whitmore Administration Building
University of Massachusetts
Amherst, MA 01003

B. If you receive wages from one or more other employers outside the University, you must fill out a Concurrent Employment Review form. State law requires you to report all outside earnings and to indicate whether you will continue working for the other employer(s). Return the Concurrent Employment Review form to the address printed above.

☞ *A copy of the Concurrent Employment Review Form follows.*

The Reform Act Relative to Fair & Effective Compensation of Injured Workers of 1992, toughened criminal sanctions for perpetrators of insurance fraud in the Workers Compensation system. Section 11D of C. 152 M.G.L. "...failure to report any earnings may subject the employee to civil or criminal penalties..."

If you have any questions concerning the Concurrent Employment Review Form, please call the Workers Compensation section of our office, (413) 545-6114. ☎

Concurrent employment form here

Calculating Workers Compensation

Wages from any job you may hold outside the University will be considered by the state WC Unit Adjuster when calculating an Average Weekly Wage (AWW) and your Compensation Rate. If you continue working at your outside job following an industrial accident, you would be paid section 35 benefits (partial incapacity) not section 34 benefits (total incapacity) under Massachusetts General Laws (M.G.L.) Chapter 152. The state WC Unit reviews concurrent employment to insure you receive the appropriate compensation based on the loss of all earnings. If you return to work at any of your jobs, adjustments must be made to the compensation rate and the payment section.

How Disability Income is Determined

Most benefits are based on your average weekly wage (including overtime, tips, etc.) for the 52 weeks prior to your date of injury. If you have not been in your current job for that long, the insurer will use the actual wages of a co-worker who had been in the same job as yours for at least 52 weeks. [Source: *DIA Guide to Massachusetts Workers Compensation System*]

Temporary & Partial Disability Benefits

Temporary Total Disability Benefits

You may qualify for total temporary disability income benefits if your injuries leave you unable to work, considering your age, training, and experience, for six or more calendar days. You can receive these benefits for up to 56 weeks as long as you are not earning any income. The first five (5) days of disability are not compensated unless you are disabled for twenty-one (21) days or more. Temporary total disability benefits equal 60 percent of your average weekly wage based on gross earnings over the 52 weeks prior to the injury, up to a maximum amount.

Partial Disability Benefits

If you are able to do some work, but have lost part of your earning capacity due to injury, you may qualify for partial benefits for a maximum of 260 weeks. For certain types of severe disability, the benefits may extend to 520 weeks.

Partial disability payments equal 60 percent of the difference between your average weekly wage (AWW) prior to the injury and the weekly wages you are now capable of earning. The maximum compensation under this section of the law is limited to 75 percent of what you would receive if you were getting total temporary benefits.

Notification of Claim Approval or Denial

The state Workers' Compensation (WC) Unit will reach a decision on the compensability of your workers compensation claim within fourteen (14) days after receiving **Form 101 - Employer's Notice of Injury Report**. The state WC Unit will notify you of their decision by sending a certified letter to your home.

If the claim is *approved*, the state WC Unit must begin paying you for lost wages. If the claim is *disapproved*, you will receive an explanation for the denial and information on how to appeal the decision. The Department of Industrial Accidents (DIA) is also notified whenever workers compensation claims are denied.

The University's Human Resources Office receives a copy of the claim decision letter, and we subsequently notify your department as to whether the claim was approved or denied.

Workers Compensation Payments

Workers Compensation checks are issued on a weekly basis and are sent directly from the state WC Unit in Boston to your home. No state and/or federal taxes or payroll deductions of any type are withheld from disability checks.

The first two Workers Compensation checks are sent to the Workers Compensation section of Human Resources at the University. After the checks have arrived, you will be asked to come to our office to endorse them. We will refund the checks back into your department's account and make adjustments to your sick time balance (crediting back up to 60% of the sick time used during your absence), state retirement, and FICA deductions.

The state WC Unit can pay on a claim for up to 180 days without prejudice, during which time payments can be stopped or modified after giving a seven (7) day notice to the injured employee and the DIA.

When Benefits May be Stopped or Reduced

After the 180-day pay-without-prejudice period has passed, the state WC Unit can stop or reduce payment only for reasons specified by the Workers' Compensation Act and regulations. If the state WC Unit contests a claim or stops or reduces payment once it's been initiated, the employee can file an Employee Claim - Form 110 to commence the dispute resolution process at the Department of Industrial Accidents after 30 days have passed from the alleged onset of disability.

Your benefits may be stopped or reduced for any of several reasons. Some of the more common reasons are:

- it is ordered by an arbitrator, administrative judge, reviewing board, or higher court;
- you returned to work (the insurer must resume benefits if within 28 days you leave work again due to the same injury);
- the insurer has been given a medical report by your treating doctor or an impartial medical examiner stating that you are capable of returning to work, and your employer has reported that a suitable position is available for you;
- you are requested to attend an evaluation by a DIA vocational rehabilitation review officer and you refuse to attend, or refuse to cooperate with the provision of vocational rehabilitation services;
- you are imprisoned after conviction for either a misdemeanor or felony.

Accruing Sick Leave & Vacation Credits

Benefited employees who are on leave due to an industrial accident, earn sick leave and vacation credits during their recuperation period. You may use this accrued time upon returning to work.

Continuation of Health Insurance

Employees, who are on a leave without pay for an entire calendar month or more, may continue receiving their basic health and life insurance coverage by paying the full cost of the premium directly to the Group Insurance Commission (GIC).

If you take a leave of absence because of a personal injury or illness, you can apply to the GIC for a reduction in the monthly premium amount by filling out a GIC Form 11. Your physician is also required to complete a portion of the form.

☞ *A copy of the Application for Reduction of Monthly Premium Form follows.*

TO: INSURED EMPLOYEES ON APPROVED LEAVE OF ABSENCE DUE TO PERSONAL ILLNESS/INJURY (INCLUDING CLAIMS FOR INDUSTRIAL ACCIDENT)

FROM: The Group Insurance Commission

RE: Application to Continue Part Cost Premiums

This Application for Reduction of Monthly Premium (Form 11) is required for all insured employees who are on approved leave of absence due to:

- Maternity
- Personal illness
- Workers Compensation/Industrial Accident

Approval of this application by the GIC will entitle you to continue part cost premiums for your group insurance coverage; this is the premium that is normally deducted from your salary.

While you are on this approved leave of absence your monthly group insurance premiums are usually not payroll deducted and you are required to remit payment directly to the GIC.

If the leave of absence is NOT approved by the Agency Head, you will be billed at the full cost premium.

THE FOLLOWING FOUR ITEMS MUST BE RETURNED TOGETHER. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

1. Page one: Completed by you, the employee
2. Page two: Completed by you and the Agency Head
3. Page three: Completed by your physician
4. Letter approving Leave of Absence: Completed by your Agency Head

SECTION ONE (To Be Completed by Employee)

Name	GIC ID NO. (usually Social Security no.) ---- ----
Street Address City	State Zip
Date of Birth	Home Telephone No. ( ) ----
Place of Employment	Occupation
Last Day of Work	Expected Date of Return to Work
Nature of Illness or Injury	

I hereby certify under the pains and penalties of perjury that I am not entitled to receive any salary, wages or other compensation from my employer and my absence is due to my own illness, or injury, and NOT the illness or injury of another person. I understand that this application shall not create an insurable interest or otherwise reinstate coverage which has been terminated. I also understand that any leave which is granted to me will be subject to periodic review by the Group Insurance Commission.

Signature of Employee _____ Date_____

SECTION TWO (To Be Completed by Agency Head/Employee)

AGENCY MUST ENCLOSE A COPY OF LETTER GRANTING LEAVE OF ABSENCE TO EMPLOYEE

1. Is this employee on Approved Leave of Absence due to Illness or Injury? Yes ☐ No ☐

If yes, reason: Illness ☐ Injury ☐ Maternity ☐ Worker's Compensation/Industrial Accident ☐

Duration of Leave From: _____ To: _____
PROVIDE SPECIFIC DATES ONLY Month/Day/Year Month/Day/Year

2. Balance of: Vac. Days ☐ Pers. Days ☐ Sick Days ☐ Comp. Days ☐

3. Last Day Employee on Payroll _____

4. Does the employee hold a Civil Service position? Yes ☐ No ☐ Does Not Apply to Agency ☐

If yes or does not apply to agency, continue to number 5.

If no, please complete the following:

It is hereby agreed that _____ will be reappointed to his/her current
(print name of employee)

position of _____, if it is available, or to a similar position to which he/she is entitled upon return from his/her medical leave of absence.

_____ _____
Signature of Agency Head/Department Head Date

I hereby agree to return to work in my current position, or a similar position, or to a position to which I am otherwise entitled at the conclusion of such leave of absence.

_____ _____
Signature of Employee Date

5. Briefly describe the Employee's job duties:

6. Please complete the following information:

Name of Agency Head _____ Title _____

Telephone Number ( ) _____

_____ _____
Signature of Agency Head/Department Head Date

SECTION THREE (To Be Completed by Physician)
(Please attach additional sheets if necessary)
1. Name of Patient:
2. Patient's Diagnosis and date of onset of illness:
3. How long have you been treating this patient for this diagnosis?
4. Describe your treatment plan and prognosis for this patient in as much detail as possible:
5. Can the patient return to work at this time? Yes ☐ No ☐
If no, when do you think the patient will be able to return to work?
6. Please indicate any alterations in the work requirements that would enable the patient to return to work
earlier. (Please explain in detail):

I hereby certify that I have examined the above named patient and certify under the pains and penalties of perjury that the information listed above is true, based upon my knowledge and belief.

Signature of Physician _____ Date _____

Please print the following information:			
Name of Physician			
Street Address	City	State	Zip
Telephone Number ( )			
Specialty			
Registration Number			

SECTION FOUR (FOR GIC USE ONLY)

VALIDATION INFORMATION

Employee's Coverage _____ Effective Date _____

Agency _____ Division _____

APPROVAL/DISAPPROVAL INFORMATION

☐ Approval From _____ To _____

☐ Disapproval reason _____

Reviewed by _____ _____
GIC Supervisor Date

COMMENTS

Medical Reports Related to Your Injury

If you receive further evaluation related to your injury, please submit reports to: Human Resources, Workers Compensation section, 181 President's Drive, Room 325, Whitmore Administration Building, University of Massachusetts, Amherst, MA 01003.

Appeal Process - When a Claim is Denied

If the state's insurer (i.e., the state Workers' Compensation (WC) Unit) denies initial liability, you will receive a certified letter giving the reasons why the workers compensation claim was contested. The state WC Unit must inform you of your right to challenge the decision by filing an appeal with the Department of Industrial Accidents (DIA). The state WC Unit also sends a copy of the denial letter to the Workers Compensation section of Human Resources at the University. We, in turn, notify your department of the state's decision.

You may wish to consult with your department head about the possibility of taking a Medical Leave or a Personal Leave. To be placed on a leave without pay (LWOP).

Claim denials can be appealed to the DIA. The appeal process involves four steps:

① **Conciliation** - An informal meeting between you, the insurer, and a conciliator from the DIA. This meeting, called conciliation, normally takes place within 12 business days of the DIA receiving the request. There is an attempt to reach a voluntary agreement between you and the insurer. No decision can be ordered at this proceeding. If a voluntary agreement cannot be reached, the status of your claim would remain the same as before, and your case could be referred to one of the DIA judges for a conference. Or you and the insurer could agree to voluntary arbitration.

② **Voluntary Arbitration** - Any time prior to five days before a conference, you and the insurer can agree to refer your disputed case to an independent arbitrator. Our department takes no further action on your claim. You present your case to the arbitrator, the state WC Unit does the same, and the arbitrator will then issue a decision that is binding on both parties.

③ **Conference** - The conference is an informal proceeding before an administrative judge. The judge learns about the case from presentations by the parties and the submission of documents such as medical reports, wage statements and affidavits from witnesses. Witnesses are not called; you just tell the judge what the witnesses would have said. Testimony is not sworn. At the conference you would need to show that you are disabled, the disability was work-related, and that any disputed medical bills were for necessary treatment. After the conference, usually within 7 days, the judge issues an order telling the insurer to pay your benefits or ruling that they are not liable for payments to you.

The conference order can be appealed by either party. This appeal must be filed with the DIA within 14 days of the issuance of the order. If either party does appeal the conference order, a formal hearing before the same judge will be scheduled.

④ **Hearing -** The hearing is a formal proceeding held before the same administrative judge who presided at the conference. Rules of evidence will apply and sworn testimony is taken. Witnesses are called and cross-examined by the opposing party. The judge may continue to gather information after the hearing. The guideline for issuance of a decision is 28 days, but this is only a guideline and it may take longer to get a decision. The decision at a hearing can be appealed to the Reviewing Board by either party. The appeal to the Reviewing Board (Form 112) must be filed within 30 days of the issuance of the hearing decision.

The Reviewing Board

The Reviewing Board is made up of six judges, three of whom will examine the hearing transcripts. They may ask for written briefs or oral arguments from either party. This panel can reverse or uphold the decision of the administrative judge.

Further Appeals

Review Board decisions can be appealed to the Massachusetts Court of Appeals.

DIA Locations

The DIA has offices located in Boston, Fall River, Lawrence, Worcester and Springfield. For additional information about the Appeal Process, contact the DIA, (413) 784-1133 ☎.

Returning to Work

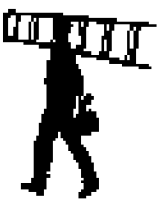
The decision to return to work and the determination of how much work you can do, what limitations there are, etc., should be made in consultation with your physician. When you are ready to return to work, contact your immediate supervisor and if necessary, develop a work schedule that can accommodate a gradual increase in time and/or restricted duty, if available.

Your employing department is responsible for notifying the Workers Compensation section of Human Resources (545-6114 ☎) as soon as it is known you will be returning to work. Human Resources prepares a Personnel Action (P.A.) to reinstate you to active status on the payroll. We also notify the state WC Unit to discontinue or adjust disability checks.

Gradual Increase to Full-Time Employment

In some cases, employees find it advisable to start back to work on a part-time basis and gradually increase their hours to a full-time schedule over a six-week period.

Example: Weeks 1 - 3 an employee works half-time (50%)
Weeks 4 - 6 the employee increases to three-quarter (75%) time



Your University paycheck and WC disability check would each be adjusted to the number of hours you are able to work.

Resumption of a Claim

A resumption of a claim is filed if you become incapacitated from a prior work related injury and are deemed disabled by a physician. *Example*: An employee returns to work after being out on Leave Without Pay due to an industrial accident. Within a period of time, the employee discovers that he or she is physically incapable of resuming the work and refiles for workers compensation.

Within 28 Days of Disability

If the resumption of your workers compensation claim is filed within 28 days of returning to work, you must give the University's Human Resources Office and the insurer (the state WC Unit) notification by certified letter within twenty-one (21) days of leaving work that the disability resulting from the injury, renders you incapable of performing work. If you fail to give notice via certified letter, within twenty-one days of leaving work, the resumption of the workers compensation claim should be filed in accordance with the procedure described on the next page.

Upon receiving the certified letter, the Workers Compensation section of Human Resources and the state WC adjuster will verify the information contained therein. Human Resources is required to provide the adjuster with: dates of lost time, your average weekly wage, and a copy of the latest medical report if one is available. If there were an opportunity for you to be placed on restricted or light duty during the recuperative period, this information would also be given to the state's WC adjuster.

The WC adjuster reviews all documentation. If the resumption claim is filed in accordance with Massachusetts General Laws c. 152, s. 8 (2), the workers compensation benefits will be re-instated. Department of Industrial Accident (DIA) Form 107 is used by the state WC adjuster to approve the claim for payment. If the claim is reinstated, you will receive an approval letter from the state WC Unit along with a copy of Form 107.

If the claim is denied, you will receive a denial letter and a copy of Form 104. Resumption denials can be appealed to the Department of Industrial Accidents (DIA). For information about the Appeal Process, contact the DIA, (413) 784-1133 ☎.

After 28 Days of Disability

If the resumption of a workers compensation claim is initiated after 28 days of returning to work, you must essentially file in the same manner as if this were a new claim. Call the Workers Compensation section of Human Resources, 545-6114 ☎ for assistance in resuming a claim.

It will be necessary for you to sign a new *Authorization for Release of Medical Records* form and have your doctor complete a *Physician's Report*. Any other information you wish to provide in relation to the injury may also be submitted to Human Resources.

The Workers Compensation section of Human Resources completes a Resumption Form and forwards all necessary forms/information to the state WC Unit in Boston within 48 hours of being notified about the claim resumption.

The state WC adjuster reviews the documentation and determines whether the claim should be approved or denied. DIA Form 107 is used by the adjuster to approve the claim for payment. If the resumption of your workers compensation claim is approved, the state WC Unit will send you an approval letter and a copy of Form 107.

If the claim is denied, you will receive a denial letter and a copy of DIA Form 104. Resumption denials can be appealed to the Department of Industrial Accidents. For information about the Appeal Process, contact the DIA, (413) 784-1133 ☎.

Return to Work Part-Time

If you are able to return to work on a part-time basis, the Benefits section of Human Resources will prepare a Personnel Action (P.A.) form to initiate a "Partial Leave Without Pay (LWOP) Due to Industrial Accident." Copies of the P.A. are distributed to the Payroll Office and to your employing department.

While on a partial leave, you would receive a salary check in the amount proportionate to your F.T.E. You also receive disability checks which have been adjusted by the state WC Unit to reflect the percentage of time you are able to work. Employees who are in benefited positions and working part-time, will accrue leave time (sick, personal, vacation) at a part-time rate.

Return to Work - Restricted Duty Policy

The Return to Work policy applies to all University employees who have experienced personal or work-related injuries or illnesses which are temporary, non-chronic impairments of short duration with little or no permanent impact. This policy allows for reasonable accommodations to be made for an employee to return to work for a specific period during recuperation.

Policy

The restricted duty time period will normally be for a maximum of six full workweeks. The employee will return to work at full pay provided the essential functions of the job can be performed. Prior to the employee's return, a detailed physician's statement describing what functions of the job the employee can and cannot perform is required. This statement must also indicate the physician's prognosis of when the employee will be able to perform all previous job duties.

The physician's statement will be provided to the employee's immediate supervisor for review. This will enable the supervisor and other management personnel to make any necessary accommodations.

In some circumstances, the six week restricted duty period may be extended if obvious medical progress is occurring. If, at the conclusion of the six week period, satisfactory medical recovery or obvious medical progress is not demonstrated, the employee will return to paid sick leave, leave without pay, workers compensation, long-term disability insurance status, or the status held prior to the return to work under this policy. In this event, it is most important that the department consult with the Division of Human Resources in order to assure the employee's rights and benefits are protected (e.g. immediate return to workers compensation, long-term disability insurance coverage, etc.).

Permanent and Total Disability Benefits

Employees who are totally and permanently incapable of doing any kind of work as a result of a work-related injury or illness, and who have exhausted the appropriate temporary disability benefits, qualify for permanent disability benefits. The amount of the benefit is equal to two-thirds (2/3) of the average weekly wage (or a minimum of 20% of the state average weekly wage) based on the 52 weeks prior to the employee's injury, up to a maximum of the state average weekly wage.

Permanent Loss of Function and Disfigurement Benefits

Under Chapter 152, section 36 of the Massachusetts General Laws, employees who sustain a permanent loss of certain specific bodily functions or surgical scars on the face, neck, or hands, may be eligible to receive a one-time lump sum payment. This benefit is in addition to other payments for lost wages, medical bills, etc. Persons injured prior to 12/24/91 have slightly different benefits. Employees who are seeking this type of benefit should contact the Department of Industrial Accidents (DIA) at the Springfield office (413) 784-1133 ☎ for more information and to request an application form. The DIA can also be reached at the Boston office by calling (617) 727-4994. ☎

Lump Sum Settlements

A lump sum settlement is a one-time payment made to a disabled employee in place of weekly compensation checks and certain other benefits. Lump sum settlements are handled by the Department of Industrial Accidents. For every $1500 received in the settlement, the employee cannot work for the employer with whom the injury occurred for 1 month.

After a lump settlement has been negotiated between the employee and the insurer, Human Resources takes the employee off **Paid Leave of Absence Due to Industrial Accident**. The former employee may request return of his or her retirement contributions to the Massachusetts State Employees' Retirement System upon his or her resignation from the University if it coincides with a lump sum settlement.

Death Benefits

Reasonable burial expenses up to $4000 will be paid in cases where the injury results in death. Surviving spouses can receive weekly benefits equal to two-thirds of the deceased worker's average weekly wage up to a maximum of the state average weekly wage. Surviving spouses become eligible for yearly cost of living increases two years after the date of the injury. If the spouse remarries, $60 a week is paid to each eligible child. The total weekly amount paid to dependent children cannot exceed the amount the spouse had been receiving.

There are two types of disability for which public employees may be retired: **accidental disability and ordinary disability.** Additional information about Accidental Disability / Ordinary Disability Retirement is available from the Benefits section of Human Resources, 545-6113 and from the State Board of Retirement (800-392-6014, 617-367-7770). ☎

Accidental Disability Retirement

State employees are eligible for Accidental Disability Retirement if they become permanently and totally incapacitated for further duty before reaching the maximum retirement age as a result of a personal injury or a hazard undergone while in the performance of duty at a definite time and place and without serious and willful misconduct on their part. There is no minimum length of service or age requirement that must be met before an employee can apply for Accidental Disability Retirement. To receive an Application Packets call the State Board of Retirement, 1-800-392-6714 or (617) 367-7770 ☎.

Ordinary Disability Retirement

Any employee who becomes permanently and totally incapacitated for further duty due to sickness or injury which is not job-related, is eligible for ordinary disability retirement provided they meet certain minimum service and/or age requirements.

Veterans. Must have at least 10 years of creditable service but may be any age less than the maximum age for their group. *Non-Veterans.* Must be less than 55 years of age. Service requirements vary. Applicants who file for retirement on or after 1/12/88, from the State Retirement System, the Teachers' Retirement System and any other system which accepts Section 31 of Chapter 697 of the Acts of 1987, must have completed at least 10 years of creditable service. All other applicants must have achieved at least 15 years of creditable service.

Involuntary Retirement

A department head may file an application with the State Board of Retirement to retire an employee for disability. A copy of the application form must be sent to the employee simultaneously. The minimum creditable service and age requirements that apply to voluntary retirees also apply to employees whose retirement proceedings are initiated by their employer. Employees who have completed 20 or more years of creditable service or have attained age 55 and have completed 15 years or more of creditable service, may request an initial hearing by the Retirement Board within 15 days of receiving a copy of the application. [Source: *Guide to Disability Retirement for Public Employees" and as authorized by M.G.L. Chapter 32, sec. 16*]

Telephone Numbers and Addresses

University of Massachusetts
Workers Compensation Section - Human Resources
181 President's Drive, 325 Whitmore Administration Building
Amherst, MA 01003
Telephone: (413) 545-6114
Facsimile: (413) 545-0483
Website: http://www.umass.edu/humres

Massachusetts State Board of Retirement
One Ashburton Place, Room 1219
Boston, MA 02108
Telephone: (800) 392-6014, (617) 367-7770
Website: http://www.state.ma.us/treasury/srb.htm

State Workers' Compensation (WC) Unit
Human Resources Division
One Ashburton Place, 3rd Floor
Boston, MA 02108
Telephone: (617) 727-3437

Workers Compensation Utilization Review Agent (pre-approves medical treatment)
Address as above
Telephone: (800) 266-7991
Facsimile: (617) 727-7816

Department of Industrial Accidents (DIA)
600 Washington Street, 7th Floor
Boston, MA 02111
Telephone: (617) 727-4900
Web Site: http://www.state.ma.us/dia/

Local DIA Offices:

Springfield
436 Dwight Street, Room 105
Springfield, MA 01103
Telephone: (413) 784-1133

Worcester
44 Front Street
Worcester, MA 01608
Telephone: (508) 753-2072